Jessop Medical Practice

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Outstanding ☆
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Jessop Medical Practice on 21 October 2016. Overall, the practice is rated as outstanding.

Our key findings across all the areas we inspected were as follows:

- There was an effective system in place for the reporting and recording of significant events. Significant events were investigated and learning outcomes were shared with the practice team to enhance the delivery of safe care to patients.
- The practice had systems in place to safeguard children and vulnerable adults.
- Clinicians kept themselves updated on new and revised guidance and discussed this at clinical meetings.
- We saw evidence of an active programme of clinical audit that reviewed care and ensured actions were implemented to enhance outcomes for patients.
- Patients told us they were treated with compassion, dignity and respect. They also said they were involved in their care and decisions about their treatment. This was corroborated bythe outcomes of the latest national GP patient survey and CQC comment cards.
- The practice planned and co-ordinated patient care with the wider health and social care multi-disciplinary team to deliver effective and responsive care to keep vulnerable patients safe. Fortnightly multi-disciplinary meetings took place to discuss and review patients' needs.
- The practice had an effective appraisal system in place and supported staff training and development.
- The practice team had the skills, knowledge and experience to deliver high quality care and treatment.
- Arrangements were in place to assess and manage risk effectively.
- Feedback from patients we spoke with on the day, and from CQC comment cards, demonstrated that some people had encountered difficulties with regards access to GP appointment. The practice were very aware of this issue and were keeping this under constant review to enhance patient experience on access.

Summary of findings

- The practice had good facilities and was well-equipped to treat patients and meet their needs. The premises were accessible for patients with impaired mobility.
- There was a clear leadership structure in place and the practice had a governance framework which supported the delivery of quality care. Regular practice meetings occurred, and staff said that GPs and managers were approachable and always had time to talk with them.
- The partnership had a comprehensive three-year business plan and associated action plan, and the practice proactively engaged with other practices and their Clinical Commissioning Group (CCG).
- The practice had an open and transparent approach when dealing with complaints. Information about how to complain was available, and improvements were made to the quality of care as a result of any complaints received.
- The practice had a patient participation group (PPG) which met on a bi-monthly basis.

We saw a number of areas of outstanding practice including:

- The partners led an innovative and committed team, and promoted a strong inclusive culture with a focus on continuous quality improvement. As a large practice, the partners recognised the importance to prioritise time to build effective relationships and communication within the team, and achieved this through daily 'catch-up' and weekly breakfast meetings to enhance their formal operational and governance frameworks.
- Significant events were thoroughly investigated and some of these were shared with the national reporting and learning system (NRLS). The NRLS ensures the learning gained from the experience of a patient in one part of the country is used to reduce the risk of something similar occurring elsewhere. Incidents were also used as a method of selecting appropriate clinical audit topics within the practice.
- We saw that a full cycle audit had been undertaken to review the practice's efficacy of coding for child safeguarding. The outcomes had been to improve the accuracy of coding, and assistance from the information technology department had ranked entries on the safeguarding register in date order to enable easier access to a list of the most recent cases where concerns had been identified. A second audit in May 2016 had highlighted that when a code was used to identify domestic violence, this needed to automatically generate a child safeguarding alert and add them to the practice's safeguarding register.
- The practice demonstrated a responsive approach by taking account of the needs of their local population, and not just their registered patients. This enabled services to be delivered closer to patient's homes. For example, a GP provided a vasectomy service for all patients within their CCG. Access to carers' clinics and counselling services for younger people were available to people outside of the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Outstanding ☆

- Staff were supported to report significant events within a supportive environment. Learning was applied from incidents to improve safety in the practice. Incidents were used to inform the selection of audit topics, and some events were reported to the National Reporting and Learning System (NRLS) to enhance learning on a wider basis.
- The practice had effective systems in place to ensure they safeguarded vulnerable children and adults from abuse and they actively audited the outcomes of coding to assess their performance in this area.
- The practice worked to written recruitment procedures to ensure all staff had the skills and qualifications to perform their roles, and had received appropriate pre-employment checks.
- Systems were in place to manage medicines on site appropriately.
- Patients on high-risk medicines were monitored on a regular basis.
- Actions were taken to review any medicines alerts received by the practice, to ensure patients were kept safe.
- The practice had effective systems in place to deal with medical emergencies within the surgery.
- The practice had developed contingency planning arrangements supported by an up to date written plan that was updated on a regular basis.

Are services effective?

Outstanding ☆

- The practice delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Regular clinical meetings took place to discuss issues including new or revised guidance, and the review of any clinical complaints or significant events.
- The practice had acquired a total achievement of 93.2% for the Quality and Outcomes Framework (QOF) 2014-15. This was slightly below the CCG average of 97%, and the national average of 94.7%. The practice explained that this was due to a

Summary of findings

merger with a practice in 2014 which had worked using different systems, and it had taken some time to streamline processes. Following our inspection, the publication of 2015-16 QOF achievement demonstrated an increase to 96%.
- The practice worked collaboratively with the wider health and social community to plan and co-ordinate care to meet their patients' needs at regular multi-disciplinary team meetings.
- Staff had the skills and experience to deliver effective care and treatment. New employees received inductions, and all members of the practice team had received an appraisal in the last year, which included a review of their training needs.
- We saw examples of a highly proactive and ongoing clinical audit programme. We observed examples of how this was being used to improve quality and enhance safe patient care and treatment.

Are services caring?

Outstanding ☆

- We observed that staff treated patients respectfully and with kindness during our inspection.
- Patients we spoke with during the inspection, and feedback received on our comments cards, indicated that they felt treated with compassion and dignity, and were given sufficient time during consultations.
- We were told of many examples that supported the delivery of exemplary care by practice staff, particularly in respect of children and younger people and vulnerable patients.
- Feedback received from community-based staff who worked with the practice was positive regarding the standards of care provided by the practice team.
- The practice had identified 2.8% of their registered patients as carers. The practice proactively identified carers and provided them with written information. Regular carers' clinics were held in the practice providing a full carers assessment with signposting to ongoing sources of support.

Are services responsive to people's needs?

Outstanding ☆

- The practice provided extended hours consultations each morning and until 8pm each Monday evening.
- Comment cards and patients we spoke with during the inspection provided mixed experiences regarding obtaining an appointment with a GP. However, the latest GP survey showed that patient satisfaction was in line with local and national averages regarding access to GP appointments, apart from access to a preferred GP.

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- Patients could book appointments and order repeat prescriptions on line. The practice participated in the electronic prescription scheme, so that patients could collect their medicines from their preferred pharmacy without having to collect the prescription from the practice.
- The practice took account of the needs of their local population, and not just their registered patients. This enabled services to be delivered closer to patient's homes. This included a vasectomy service, access to carers' clinics, and counselling services for younger people which were available to people outside of the practice.
- The practice implemented improvements and made changes to the way it delivered services as a consequence of feedback from patients.
- The premises were tidy and clean and well equipped to treat patients and meet their needs. The practice accommodated the needs of patients with a disability, including access to the building through automatic doors.
- The practice reviewed any complaints they received and dealt with these in a sensitive and timely manner. Information about how to make a complaint was available for patients. Learning from complaints was used to improve the quality of service.
- If patients at reception wished to talk confidentially, or became distressed, they could be moved to a private room besides the waiting area to ensure their privacy.

Are services well-led?

Outstanding ☆

- The partners led an innovative and committed team. There was an inclusive and supportive culture with a clear focus upon continuous quality improvement
- The partners had produced a comprehensive three-year business plan supported with agreed actions, goals and objectives to reflect the aspirations of the partnership. All partners took part in an annual strategic planning day to inform their business planning process. Staff and the PPG took part in discussions that helped to shape priorities.
- The provider was committed to the delivery of high quality care and promoting good outcomes for their patients.
- The practice had a history of working with their neighbouring practices, and collaborative working arrangements had been developed including the sharing of resources. Achievements included the employment of notes summarisers who worked

Summary of findings

across four of the six practices; and the development of a service for emotional and mental health support for children, and the implementation of carer's clinics accessible by all six local practices.

- The practice demonstrated a wider community focus and provided services on site which could be accessed by patients who were registered elsewhere, benefiting the local population.
- GPs and nurses had defined lead clinical areas of responsibility providing expert advice to patients and acting as a resource for their colleagues.
- The practice had developed a range of policies and procedures to govern activity. There was an active clinical governance group.
- The practice proactively engaged with their CCG and worked with them to enhance patient care and experience. GP partners contributed to many CCG groups and networks, and this involvement helped to keep the practice at the forefront of local developments.
- The partners reviewed comparative data, such as referral rates, provided by their CCG and ensured actions were implemented to address any areas of outlying performance.
- Staff felt well supported and valued by the management team. The practice held regular staff meetings to ensure good communication.
- The practice proactively sought feedback from patients and staff, and acted upon this to constantly improve service delivery. The practice had an active Patient Participation Group (PPG) which met every two months which worked with the practice and helped to influence and support developments.
- There was an emphasis on innovation with the uptake of new schemes and opportunities to pilot new ways of working. The practice had successfully implemented full patient access to their notes, and were working on a scheme to promote more interactive GP consultations.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Outstanding ☆

- People aged 65 years and over accounted for 20.7% of the practice's registered patients which was higher than the CCG average of 17.6% and the national average of 17.1%. Each older person had a named GP and the practice encouraged continuity of care with the same GP whenever possible.
- The practice worked with a care co-ordinator and community matron as part of a multidisciplinary community support team to proactively care for frail patients, and to develop bespoke care plans which were shared with out-of-hours services. These patients were flagged on the practice computer system and were prioritised if they contacted the surgery. Fortnightly multi-disciplinary meetings were held to review vulnerable patients to plan and deliver ongoing care and support appropriate to their individual needs.
- The practice provided medical cover in work-hours for patients admitted to Ripley Community Hospital. Three GPs shared this responsibility, and visited the hospital twice weekly, with additional visits undertaken according to patients' needs.
- Older patients with multiple health issues received an annual (or more frequent if required) review to re-assess their condition and to ensure the medicines remained suitable for their needs. This would be arranged at the patient's home if necessary.
- Longer appointment times could be arranged for patients with complex care needs. Home visits were provided for those unable to attend the surgery.
- The practice provided care to over 160 patients across 16 care homes. Each home had at least one named GP to help with continuity of care. We spoke with managers at two of the care homes who told us that they always received a responsive and caring service.
- Uptake of the flu vaccination for patients aged over 65 was 71%, which was in line with the local average of 73% and the national average of 70.5%.
- The premises were suitable for older people, including those with hearing difficulties and wheelchair users. All clinical rooms were on ground floors and the practice entrance had automatic doors.

Summary of findings

People with long term conditions

Outstanding ☆

- The practice maintained registers of people with long-term conditions, with recall processes to invite patients for reviews of their conditions and medicines. Comprehensive computer templates had been developed to use for reviews which included health promotion information and individual health care plans that were printed and given to the patient.
- Patients with multiple conditions were usually reviewed in one appointment to avoid them having to make several visits to the practice.
- Annual reviews included patients who were housebound or resided in a care home.
- The call and recall system was co-ordinated by the administration team. Patients were seen as part of the routine appointment system, rather than by dedicated clinics. This gave more flexibility for patients in attending at a time that was suitable for them.
- QOF achievements for clinical indicators were generally in line with CCG and national averages. For example, the practice achieved 94.2% for diabetes related indicators, which was 1.1% higher above the CCG average, and 5% above the national average in 2014-15. There was an overall lead GP for QOF, supported by individual GPs acting as clinical leads for specific long-term conditions. The nurse manager was also assigned as the long term conditions nurse.
- The nurse manager was an approved trainer in a defined evidence-based diabetes education programme called X-PERT Diabetes'.
- Joint clinics were held every six weeks with the local diabetes nurse specialist nurse to see more complicated patients to reduce referrals and further enhance the nurse manager's skills.
- The practice had established effective relationships with the local Borough Council, and worked with the housing officer to offer heating/housing support for individuals with chronic obstructive airways disease.

Families, children and young people

Outstanding ☆

- 18.2% of registered patients were under 18 years old, and the practice adapted its services to meet this groups specific needs.
- Telephone access was available on the day for parents of children and any urgent needs were accommodated by a face-to-face consultation. Children under five were prioritised to be seen. Minor illness appointments were available on the day with the nurse practitioner

Summary of findings

- The practice was committed to safeguarding children and young people, with effective child safeguarding arrangements in place. There was a designated lead GP, supported by another GP and dedicated support from one of the administration team. The practice held regular meetings to discuss cases, and routinely invited community midwives, health visitors and school nurses to attend these. Relevant patient records were flagged so that clinicians were aware of children and young people where concerns have been raised. We saw that records were audited regularly to ensure safety.
- The practice provided eight-week baby checks, and postnatal reviews. They also hosted regular midwifery services at both sites, and health visitor clinics including drop-in sessions.
- Childhood immunisation rates were marginally above local averages. Overall rates for the vaccinations schedule given to children up to five years of age ranged from 73.8% to 97.8% (local averages 66.7% to 98%).
- The practice offered a full range of contraception services, including access to emergency contraception and the fitting of intrauterine devices and contraceptive implants. The practice encouraged chlamydia screening uptake with anonymous collection points available.
- The practice provided a vasectomy service for patients registered with the CCG's practices, creating easier access for local people. There had been 88 vasectomies performed in the past 12 months, from a purpose-built enhanced minor operations suite. The practice had received high levels of positive feedback from patients who had received the service.
- The practice hosted a counselling service for younger people provided by Relate, and were involved with a local pilot to increase capacity to see more patients, with other local practices and schools.
- The practice welcomed mothers who wished to breastfeed on site, and offered a dedicated breastfeeding room for this, which included baby changing facilities. The environment was child friendly, with a play-area in the waiting room, and large accessible consulting rooms which facilitated access for pushchairs.

Summary of findings

Working age people (including those recently retired and students)

Outstanding

- The practice provided extended hours consultations from 7.30am each morning and late-opening each Monday until 8pm. This included nurse appointments, for example, to provide cervical screening or reviews of long-term conditions, enabling easier access for working people.
- Telephone consultations and advice were offered each day when this was appropriate, so that patients did not always have to attend the practice for a face-to-face consultation.
- The practice offered on-line booking for appointments and requests for repeat prescriptions. Participation in the electronic prescription scheme meant that patients on repeat medicines could collect them directly from their preferred pharmacy.
- The practice provided new patient health assessment checks and NHS health checks.
- The practice hosted the Live Life Better Derbyshire service who provided advice, support and signposting to assist with smoking cessation, weight management and healthy lifestyle advice.
- The practice actively promoted health-screening programmes to keep patients safe. The practice's uptake for the cervical screening programme was 83.3%, in line with the CCG average of 83.5% and slightly above the national average of 81.8%. Uptake of breast cancer screening was encouraged, and rates were slightly higher than averages.

People whose circumstances may make them vulnerable

Outstanding

- The practice provided care to 161 people in local care homes. There were named GP leads for each care home (including establishments for serious mental illness and learning disabilities), and tried wherever possible for the named leads to be involved on any visits to aid continuity and build relationships with the carers/nurses. The practice proactively worked with their medicines management team to review care home patients' medicines regularly, often on joint visits.
- Patients with end-of-life care needs were reviewed at a quarterly multi-disciplinary team meeting including a lead GP, district nurses, and a Macmillan nurse.
- The practice used care plans for the most vulnerable patients including those at end of life. A template was used for patients

at the end of life to ensure key information was available to ensure continuity of care for the patient. This included the patient's preferred place of care and whether a Do Not Attempt Resuscitation order was in place.

- Newly bereaved relatives or carers were contacted by GPs to offer condolences and see if any support may be required.
- The practice held a register of vulnerable patients and there was a designated lead GP for adult safeguarding. Cases were regularly discussed cases and GPs participated in serious case reviews and vulnerable adult risk management meetings wherever possible. Staff had received adult safeguarding training including domestic violence, PREVENT (radicalisation) and Deprivation of Liberty Safeguards, and were aware how to report any concerns relating to vulnerable patients. Their safeguarding audits had identified improvements which could improve the identification of patients who may be at risk as a result of domestic violence and changes had been implemented to improve the practice systems.
- The practice had 138 people on their learning disability register which was above the national average. The practice had undertaken an annual health review for 75% of their patients with a learning disability in the last 12 months. A specific computer template was available to ensure the reviews were comprehensive, and patients were encouraged to have the flu vaccination.
- Homeless people and refugees could register with the practice, and the practice worked with local services to address individual need.
- The practice had low numbers of patients whose first language was not English. These patients were able to access interpreter services if required.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

- The practice provided care for patients diagnosed with a serious mental illness which comprised 1% of their registered patient list, including individuals in two designated care homes. The practice had a designated lead GP for mental health.
- The practice achieved 95.1% for mental health related indicators in QOF, which was 1.8% below the CCG and 2.3% above the national averages. Exception reporting rates at 23.6% were higher compared against local (16.9%) and national rates (11.1%). However, the practice were able to provide data which demonstrated a lower exception reporting rate and data for 2015-16 also showed that the rate had continued to decrease.

Summary of findings

- These patients were offered and encouraged to have annual care reviews and care planning. The annual reviews were performed by a GP, often with a support worker present. A template had been developed to include lifestyle measures, cardiovascular risk assessment, and medicines monitoring. 85.9% of patients with severe and enduring mental health problems had a comprehensive care plan documented in the preceding 12 months according to 2014-15 QOF data (CCG average 91.8%;national average of 88.5%).
- The practice had established links with the local consultant adult psychiatrist. Regular discussions took place and the psychiatrist had attended practice meetings to discuss effective ways of joined-up working. The psychiatrist regularly accompanied the lead GP for mental health on joint ward rounds to a home for patients with challenging behaviour to enhance care and provide access to expert advice.
- The practice hosted counselling and psychological therapy services at both sites to ensure these were easily accessible for their patients.
- The practice told patients experiencing poor mental health and patients with dementia about how to access local services, support groups and voluntary organisations. Information was available for patients in the waiting area.
- There were 188 patients (1.1%) registered patients who had been diagnosed with dementia. The health care assistant helped to screen for new patients with an assessment tool. 89.8% of people diagnosed with dementia had had their care reviewed in a face-to-face meeting in the last 12 months. This was in slightly above local and national averages of 85.4% and 84% respectively with aligned exception reporting rates.

Summary of findings

What people who use the service say

The latest national GP patient survey results were published in July 2016 and the results showed the practice was generally performing above, or in line with, local and national averages. There were 238 survey forms distributed to patients, and 120 of these were returned. This was a 50% completion rate of those invited to participate, and equated to 0.7% of the registered practice population.

- 95% of patients found the receptionists at this surgery helpful compared against a CCG average of 88% and a national average of 87%.
- 81% of patients said they would recommend this surgery to someone new to the area compared to a CCG average of 80% and the national average of 78%.
- 95% of respondents said the last nurse they saw or spoke to was good at listening to them compared to a CCG average of 93% and the national average of 91%.

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards of which 28 (93%) contained positive feedback about the care provided by the practice team. Patients wrote that they were treated in a dignified and respectful manner; that staff were helpful and polite; that they always felt listened to during their consultations; and that they received appropriate advice and treatment. Six cards contained mixed comments including positive experiences about their care, but with reference to difficulties experienced in accessing a consultation with a GP. Two cards contained a negative response in respect of obtaining a GP appointment.

We spoke with seven patients during the inspection who provided positive feedback regarding the caring and compassionate approach adopted by the practice team, reflecting the feedback within the comment cards. Four patients told us they had experienced difficulties in obtaining a routine GP appointment, although most patients said they could get an urgent appointment when this was required. Three patients said that appointments often ran late, however we saw an analysis of GP waiting times over the previous three months which showed an average wait of less than five minutes after the allotted appointment time to see a GP.

Jessop Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.**The team included a GP specialist advisor and a second CQC inspector.

Background to Jessop Medical Practice

Jessop Medical Practice provides care to approximately 17,000 patients across two sites. The main site is situated in Leabrooks, a small urban locality in the Amber Valley district of Derbyshire. There is also a branch surgery four miles away at Church Farm, Ripley, Derbyshire. DE5 3TH. We visited the main site at Leabrooks during our inspection.

The practice provides primary care medical services via a General Medical Services (GMS) contract commissioned by NHS England and NHS Southern Derbyshire Clinical Commissioning Group.

The registered patient population are predominantly of white British background. The practice age profile demonstrates slightly higher number of patients aged 40 years and above, and generally lower numbers of people aged below 40 in comparison to the local and national averages. People aged 65 and above comprise 21% of the registered practice population. The practice is ranked in the fifth more deprived decile and serves a mostly residential area. Deprivation scores (2015) at 22.4 were in alignment with the local and national average.

The practice operates from purpose-built premises at each site. The main site at Leabrooks opened in 2011. All patient services within the practice are provided on the ground floor of the building, whilst the upper floor is utilised for administration.

The practice is run by a partnership of 14 members, which consists of 13 GPs partners (seven females and six males) and the practice manager. The partners employ a part-time female salaried GP. The provider is an established training and teaching practice and accommodates GP registrars (a qualified doctor who is completing training to become a GP), and medical students.

The nursing team is led by a full time nurse manager and consists of a nurse practitioner, four practice nurses, and two health care assistants. The clinical team is supported by a practice manager, a deputy practice manager, and two senior receptionists who manage a team of 21 secretarial, administrative and reception staff, including an apprentice.

The practice opens at 7.30am each morning until 8pm on a Monday and from 7.30am until 6.30pm from Tuesday to Friday. The practice closes at 1.30pm for one afternoon on ten months of the year for staff training.

GP consultations commence each morning with extended hours early appointments from 7.30am and the latest GP appointment is available at 5.50pm (7.50pm for extended hours on a Monday evening).

The practice has opted out of providing out-of-hours services to its own patients. When the practice is closed patients are directed to Derbyshire Healthcare United (DHU) via the 111 service.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework (QOF) data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

How we carried out this inspection

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Southern Derbyshire Clinical Commissioning Group to share what they knew.

We carried out an announced inspection on 21 October 2016 and during our inspection:

- We spoke with staff including GPs, the nurse manager and a practice nurse, the practice manager and deputy practice manager, and a number of reception and administrative staff. In addition, we spoke with a community matron, a care co-ordinator, the CCG pharmacist, a district nurse, managers at two local care homes and a matron at the community hospital. We also spoke with seven patients who used the service, and three members of the patient participation group, including the recently retired long-serving PPG chair.
- We observed how people were being cared for from their arrival at the practice until their departure, and reviewed the information available to patients and the environment.
- We reviewed 30 comment cards where patients and members of the public shared their views and experiences of the service.
- We reviewed practice protocols and procedures and other supporting documentation including staff files and audit reports.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record and learning

There was a strong, open and embedded culture at the practice in respect of patient safety and the practice used every opportunity to learn from incidents. There was an effective procedure in place for reporting and recording significant events

- Forty significant events had been reported over the course of the last 12 months.
- Staff were encouraged to report incidents within a supportive 'no blame' culture.
- An electronic significant event reporting form was readily available to all staff.
- Incidents were investigated and assessed to determine the potential severity of the incident and consider if any urgent or remedial action was indicated to protect patients or staff.
- Completed incident forms were sent to a designated lead GP for significant events and the practice's clinical governance group. Actions that were undertaken in response to an incident were discussed and learning was shared with the practice team. We saw documentation that reflected that agreed actions had been completed, and minutes from meetings where incidents had been discussed.
- Patients received an apology and appropriate support when there had been an unintended or unexpected incident. The practice informed us they would either meet with the individual concerned or write to them, depending on the particular circumstances involved.
- The practice undertook an annual review of significant events with the team to consider any recurrent themes that may have emerged, and to ensure that all follow-up actions had been completed in full.
- Some incidents were used to inform the selection of practice audit topics. For example, a significant event identified that a patient had been authorised a contraceptive prescription for a year, although risk factors had been identified. This resulted in raising the awareness of specific guidelines and inclusion within the practice audit programme.
- Relevant incidents were also reported to the National Reporting and Learning System (NRLS) which is a central database of patient safety incident reports across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety which are then shared to promote best practice. We observed that the practice had reported events such as vaccination and prescribing incidents or near misses, and potential fraud in obtaining a prescription to the NRLS. The practice was the highest reporting practice to the NRLS within the CCG with eight NRLS referrals in the preceding 12-month period.
- We saw evidence of learning that had been applied following significant events. For example, there had been an incident in which a patient arrived late for a test and could not be seen as the clinician had started another clinic. This was reviewed by the practice who agreed that each case should be considered on an individual basis so that a patient potentially in need of treatment was not delayed. The outcome was that reception staff should seek a GP's advice with similar occurrences in the future.

The practice had a process to review all safety alerts received including those from the Medicines Health and Regulatory Authority (MHRA). MHRA alerts were cascaded to all clinicians and these were discussed at the next relevant staff meeting. When concerns were raised about specific medicines, patient searches were undertaken to identify which patients may be affected. Effective action was then taken by clinicians to ensure patients were safe, for example, by reviewing their prescribed medicines.

The practice maintained a log of all the alerts received which included the actions taken in response to each alert.

Overview of safety systems and processes

The practice had systems and procedures in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local guidance. Practice safeguarding policies were accessible and up-to-date, and codes and alerts were used on the patient record to identify vulnerable children and adults. There was a designated lead GP for safeguarding both children and adults, who had received training at the appropriate level in support of their lead role. The lead GP was supported in this role by another GP and an administrator, which provided

effective management and oversight of child safeguarding. The lead GP worked with the administrator throughout the week as part of a proactive approach in following up any active concerns.

- The health visitor, school nurse and midwife were invited to attend a quarterly meeting with the lead GP and an administrator every month to discuss any child safeguarding concerns. Any relevant new information would be updated within the patient record, and communicated to the team. GPs ensured that reports were provided to inform any child safeguarding case conferences that took place.
- We saw that a full cycle audit had been undertaken to review the practice's efficacy of coding for child safeguarding. The outcomes had been to improve the accuracy of coding, and assistance from the information technology department had ranked entries on the safeguarding register in date order to enable easier access to a list of the most recent cases where concerns had been identified. A second audit in May 2016 had highlighted that when a code was used to identify domestic violence, this needed to automatically generate a child safeguarding alert and add them onto the practice's safeguarding register. The practice had implemented these actions.
- Practice staff demonstrated they understood their responsibilities for safeguarding and all had received training relevant to their role.
- Vulnerable adults were monitored by the practice team and were reviewed as part of regular multi-disciplinary meetings. The practice also engaged with vulnerable adult risk management (VARM) multi-agency meetings when this was required.
- A notice in the reception and the consulting rooms, and the practice website, advised patients that a chaperone was available for examinations upon request. Either a practice nurse, a health care assistant or a receptionist would act as a chaperone if this was requested by the patient. The receptionist chaperones had undertaken training to support their chaperoning duties and had received an appropriate disclosure and barring check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Patients were informed that they could decline to have a receptionist chaperone if they preferred for this to be undertaken by a nurse. A practice chaperone policy was available.
- We observed that the practice was maintained to high standards of cleanliness and hygiene. The nurse manager was the appointed infection control lead, who had established links with the local infection prevention and control team (IPCT) for advice and support. The nurse attended quarterly IPCT meetings which provided networking opportunities with other local practice infection control leads. Infection control policies were in place, including needlestick injuries and the management of spillages. The infection control lead had undertaken an infection control audit in February 2016. This resulted in an action plan to address a number of issues that were identified, and we observed that this had been completed. For example, stained carpets in the corridor at one site had been replaced with laminate flooring, and the practice was planning to do the same with carpeting in consulting rooms. Practice-led infection control audits were planned annually to monitor adherence to standards, although regular spot-checks took place in-between. Practice staff received information on infection control as part of new staff inductions, and on-line training was available. Hand-washing audits were undertaken periodically with staff.
- The practice used a contractor to provide their cleaning on a daily basis. A written schedule of daily, weekly and monthly cleaning tasks were available and there were arrangements in place to monitor cleaning standards. There was regular liaison in place between the practice manager and contractor to ensure any problems were dealt with promptly and effectively.
- We reviewed four staff files and found that the necessary recruitment checks had been undertaken prior to commencing work with the practice. For example, proof of identification, qualifications, registration with the relevant professional body and the appropriate checks through the DBS.
- We saw evidence that clinical staff had received vaccinations to protect them against hepatitis B.

Medicines management

Are services safe?

- The arrangements for managing medicines in the practice, including emergency medicines and vaccinations were safe. Regular medicines stock checks including expiry dates were undertaken.
- Blank prescription forms and pads were securely stored, and a system was in place to monitor the distribution of prescriptions within the practice.
- There was a process in place to support the safe issue of repeat prescriptions.
- Effective systems were in place to monitor patients prescribed high-risk medicines. We saw an example of an annual audit that looked at certain types of high-risk medicines to ensure patients were being monitored effectively to keep them safe.
- Signed and up-to-date Patient Group Directions were in place to allow nurses to administer medicines in line with legislation, and healthcare assistants administered medicines against a patient specific directive from a prescriber.
- The practice reported any concerns regarding controlled drugs (prescription medicines controlled under the Misuse of Drugs legislation), and one case was recently featured within a regional newsletter to share learning. The practice was considering introducing an identification check for the collection of controlled drugs prescriptions following a recent incident, and was working with other organisations to consider a suitable approach.

Monitoring risks to patients and staff

- A practice health and safety policy was available and the practice fulfilled their legal duty to display the Health and Safety Executive's approved law poster in a prominent position.
- Documentation was available to support the control of substances hazardous to health.
- There were a number of generic risk assessments available. The process was not always being used proactively to manage any new or emerging risk areas, including those identified through the incident reporting procedure.
- A fire risk assessment had been undertaken in June 2016. This had resulted in an action plan and we saw evidence that the practice had responded to the issues that had been identified. Fire alarms, emergency lighting, and extinguishers were tested and serviced regularly to ensure they were in full working order. Staff had received annual fire training, and the practice undertook trial evacuations at least annually to ensure staff were aware of the procedure to follow in the event of a fire.
- All electrical equipment was regularly inspected to ensure it was safe to use, and medical equipment was calibrated and checked to ensure it was working effectively. We saw certification that this had been completed by external contractors in the last 12 months.
- The practice had a documented risk assessment for legionella (legionella is a term for a particular bacterium which can contaminate water systems in buildings). Infrequently used water sources were run regularly as a control measure, and this was supported by documentation.
- There were arrangements in place for planning and monitoring the number and mix of staff needed to meet patients' needs. GPs and the practice team worked together to plan leave and ensure adequate cover was in place for all staffing groups to ensure safety and service continuity. GPs worked additional clinical sessions within their administration time to help pressure with appointments around bank holidays.
- The practice had a system to manage incoming correspondence to ensure that any actions, such as a change to a patient's medicines, were completed promptly. GPs undertook responsibility for coding. On the day of our inspection we observed that some correspondence was awaiting coding, which had fallen just outside of the practice standard of two days. However, the practice was aware of this issue which had arisen primarily as a consequence of preparation for our inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents:

- Staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and four oxygen cylinders with masks. The practice had specific equipment for emergency situations for children including paediatric pulse oximetry (a non-invasive method for measuring oxygen

levels in the blood), age-appropriate emergency medicines, and paediatric oxygen masks. Guidelines were available on resuscitation trolleys to remind clinicians of recommended doses.

- Emergency medicines were easily accessible to staff in a secure area of the practice and were in date.
- An emergency alert system was available on computers to inform other staff to assist rapidly with any emergency situation, such as if a patient was to collapse. Consulting rooms also had access to a panic alarm.
- The practice had a business continuity plan for major incidents such as power failure or building damage, which was regularly reviewed and updated, most recently in April 2016. The practice had identified potential alternative locations to temporarily co-ordinate and deliver services in case an incident made the site inaccessible. Copies of the plan were available off site.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice delivered care in line with current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines and local guidance. There was an identified GP lead to review any new or revised guidance and updates were discussed at weekly clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2014-15) were 93.2% of the total number of points available, which was 3.8% below the CCG average, and 1.5% below the national average. Exception reporting rates at 10.9% were in line with the local average of 11.1% and the national average of 9.2%. Exception reporting is the removal of patients from QOF calculations where, for example, a patient repeatedly fails to attend for a review appointment. A low figure for exception reporting usually demonstrates a proactive approach from the practice to engage patients in attending for regular reviews of their condition.

QOF data from 2014-15 showed:

- Performance for diabetes related indicators was 94.2%, which was in line with the CCG average of 93.1% and slightly above the national average of 89.2%. However, there were higher exception reporting rates at 18.2% (local 13.4%; national 10.8%)
- The practice achieved 75.9% for clinical indicators related to chronic obstructive airways disease. This compared to a local average of 98% and a national average of 96%, although there was lower exception reporting at 5.4% (local 15.4%; national 12.3%)
- QOF achievement for 2014-15 for asthma was 86% which was below local and national averages (98.9% and 97.4% respectively). This was achieved with exception reporting rates of only 2.4% (local 10%; national 6.8%).
- Dementia related indicators scored 98.1%. This was in line with the CCG average and 3.6% higher than the national average. Exception reporting rates were in line with local and national averages.
- The practice had worked effectively to enhance their QOF achievement since the merger of the two practices in 2014. When the two practices merged, they were using wholly different systems and it had taken time to create a unified approach. This accounted for the discrepancies in QOF over the last two years, although we observed that this situation was now mostly resolved. Practice supplied data (subject to external verification) demonstrated that QOF achievement for 2015-16 had increased to 96%.

There was evidence of quality improvement including an active programme of clinical audit.

- We saw that 17 clinical audits had been undertaken in the last 12 months, including five full-cycle audits where changes had been implemented and monitored with positive outcomes for patients. We reviewed a full cycle audit undertaken on monitoring the kidney function of patients prescribed long-term non-steroidal anti-inflammatory medicines, via an annual blood test. A second cycle audit had demonstrated an improvement from 81% in 2013 to 96% in 2015. The most recent audit showed that achievement had been maintained with a minimal decrease to 95%. The audit concluded with several suggested means of further increasing adherence to the standard of 100% compliance (with reasonable deviations of 1-2%).
- The practice had undertaken five further audits on topics relating to information governance and referrals.
- There were additional comprehensive audits of minor surgery including the vasectomy service provided by the practice.
- The practice worked with a CCG primary care pharmacist and medicines management technician who provided regular input. The pharmacist had assisted with review of medicines in local care homes. We spoke with the pharmacist who told us that the practice engage well with their team to discuss specific work priorities.
- The practice had volunteered to be involved in a trial led by Public Health England to reduce demand for antibiotic medicines. Data demonstrated that the practice were low prescribers of antibiotics within their CCG.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

- The practice participated in local benchmarking activities. For example, they reviewed comparative data provided by the CCG including referral rates and hospital admissions.

A practice nurse had taken on the development of templates and computer systems to maximise usage and time management of each appointment, ensuring best practice was applied to each treatment. For example, the layout of each template had been standardised to ensure ease of use and certain boxes reaffirmed that the correct procedure or protocol was being used for the corresponding treatment. The computer system had been set up to prompt if blood pressure, pulse and weight had not been taken recently, so that this could be done in order to keep health information up to date.

The practice had embraced the philosophy of 'marginal gains' and developed several ways in which small amounts of clinical time could be saved to maximise productivity. For example, a treatment room closest to the waiting area had been specially equipped to manage patients coming in for regular blood test to manage the dosages of their medicines. As these were set as five-minute appointments, the overall benefit was significant.

At the heart of these developments was the need to maximise clinical time for patients, reducing the need for additional recalls and further appointments as well as ensure patient safety by making up to date clinical guidance and dosages part of the system for reference when needed.

Effective staffing

- The practice provided an induction programme for all newly appointed staff. We reviewed examples of these which were specific to individual roles, and we saw evidence that topics were signed off once completed. Staff told us they were well supported when they commenced their roles with shadowing opportunities and had easy access to support from their colleagues.
- Staff told us that they received an annual appraisal and we saw documentation that evidenced this. The appraisal included a review of the previous year's performance, and the setting of objectives and the identification of learning for the forthcoming year. We spoke to members of the team who informed us of how learning opportunities had been discussed during their appraisal and had been supported by the practice. For example, staff informed us how they were allowed time and had received funding from the practice to undertake secretarial and coding courses to assist their skills and personal development. The nurse manager was being supported by the practice to attend a prescribing course and received mentorship from the GPs as part of this development. The staff appraisal was also used as an opportunity to consider an individual risk assessment for each team member including for example, any health issues.
- Staff received regular training that included safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training including guest speaker talks from representatives from organisations such as Relate and Independent Mental Capacity Advocacy (IMCA). Clinicians also participated in relevant CCG led protected learning time events.
- The practice ensured role-specific training with updates was undertaken for relevant staff, for example, administering vaccinations and taking samples for the cervical screening programme. The health care assistant had undertaken training to perform ear syringing, and administer B12 injections (to address deficiencies of a particular vitamin in the blood), and was undertaking further training to perform Doppler testing (a test conducted to measure the blood pressure in the arms or legs using a special machine).
- The practice participated in the local college apprenticeship scheme for administrative and reception roles, and had previously recruited a member of the team from this route.
- There was a plan to provide support for nursing staff for their forthcoming revalidation. This included time to attend courses and updates.
- Daily mentor and debrief sessions were in place to support GP registrars in their roles.

Coordinating patient care and information sharing.

- The information needed to plan and deliver care and treatment was available to clinicians in a timely and accessible way through the practice's electronic patient record system. This included care plans, medical records, and investigation and test results. We viewed an example of a care plan used for patients and saw

that this was appropriate. Summary care plans for vulnerable patients were accessible by other providers, for example patients at the end-of-life, to ensure continuity of care.

- Fortnightly multi-disciplinary meetings (known as the Community Support Team) were held at the practice to assess the range and complexity of patients' needs, and to plan ongoing care and treatment for vulnerable patients including those at high risk of hospital admission and vulnerable patients. This meeting included a lead GP who met with representatives from community based services usually including district nursing team staff, a community matron, a physiotherapist or occupational therapist, a community psychiatric nurse, and a social services representative. Minutes were produced from the meeting as a reference for other clinicians within the practice. In addition, the lead GP met with the community matron and care co-ordinator each week to review those patients with more complex needs.
- Multi-disciplinary meetings took place each quarter to review patients on the practice's palliative care register. This included representation from the designated lead GP with district nursing staff, the local community specialist palliative care nurse, and a Macmillan nurse.
- Weekly 'breakfast meetings' took place in which clinicians met and reviewed any new guidance or would discuss other clinically related issues. Every three months, this meeting focused on significant incidents and complaints. Providers of different community based services were occasionally invited to attend this meeting to raise awareness of what was available, and to establish effective communication channels.
- The GPs and nurses met informally for coffee at the end of morning surgery for clinical discussions and information sharing. This facilitated access for other staff within the practice, and community based health care staff to talk with clinicians with regards any important issues.
- Monthly nurse meetings were held at the practice. These were minuted and we observed that the last meeting included discussions on infection control and vaccination updates.

Consent to care and treatment

- Staff sought patients' consent to care and treatment in line with legislation and guidance. We saw an example of a consent form used for minor surgical procedures.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). A GP had completed a DoLS audit in May 2016. This was undertaken to raise awareness of legal requirements and to improve coding. The outcome was to update and accurately code patients subject to DoLS and to ensure that communication with care homes was effective in providing any update regarding any change in a patient's DoLS status.
- When providing care and treatment for children and young people, staff followed national guidelines to assist clinicians in deciding whether or not to give sexual health advice to young people without parental consent.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- The practice hosted the Live Life Better Derbyshire service on site for patients to receive advice and signposting to relevant support schemes, for example, to stop smoking and to assist in weight management and promote more active lifestyles.
- The practice provided new patient health checks, and NHS health checks for patients aged 40-74. A total of 1,221 NHS health checks had been completed since the introduction of this scheme in 2009.
- The practice had undertaken an annual health review for 75% of their patients with a learning disability in the last 12 months. This was a significant achievement due to the number of people on their learning disability register (138 patients in total) which was above the national average.
- The practice's uptake for the cervical screening programme was 83.3%, which was in line with the CCG average of 83.5%, and the national average of 81.8%. Exception reporting was below both local and national percentages.
- National screening programme data showed the uptake for bowel cancer screening was in line with local and

Outstanding ☆

Are services effective?

(for example, treatment is effective)

national averages. Breast cancer screening for females aged 50-70 years old in the last three years was slightly higher at 78.2% when compared with local (75.8%) and national averages (72.2%).

- The practice had participated in a local cancer project and data from 2015 showed the practice was above local and national rates for two week suspected cancer referrals, with a higher conversion rate in which patients were subsequently treated for cancer.
- Childhood immunisation rates for the vaccinations given to children aged up to five years of age were mostly in line with local and higher than national averages. The overall childhood immunisation rates for the vaccinations given to under two year olds ranged from 74.5% to 97.8% (local average 72.5% to 97%); national average 73.3% to 95.1%) and five year olds from 73.8% to 97.3% (local average 72.1% to 98%; national average 81.4% to 95.1%).
- Uptake of the flu vaccination for patients aged over 65 was 71%, which was in line with local (73%) and national (70.5%) averages. Flu vaccination rates for 'at risk' patients under 65 at 44% was in alignment with the local average of 44%.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations and treatments.

Throughout our inspection, we observed that members of staff were courteous and helpful to patients and treated them with dignity and respect. A caring and patient-centred approach was demonstrated by all staff we spoke with during the inspection.

Feedback received via comment cards, and from patients we spoke with on the day, told us that patients consistently felt that they were treated with compassion, dignity and respect by clinicians and the reception team. Results from the national GP patient survey in July 2016 showed the practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 90% of patients said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 90% and the national average of 89%.
- 94% of patients said the last GP they saw gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 92% of patients said the last nurse they spoke to was good at treating them with care and concern compared to a CCG average of 92%, and the national average of 91%.

These findings were corroborated by outcomes from surveys carried out by the patient participation group, and an independent patient survey commissioned by the partners.

We spoke with community-based staff who told us that the practice team communicated with them effectively, and that GPs were approachable and accessible. They told us that the practice worked in collaboration with them and responded promptly to address patients' needs.

Care planning and involvement in decisions about care and treatment

Patients told us that they were involved in decision making about the care and treatment they received, and feedback on the patient comment cards we received aligned with these views.

Results from the national GP patient survey showed results were in line with local averages and national averages, in relation to questions about their involvement in planning and making decisions about their care and treatment. For example:

- 86% of patients said the last GP they saw was good at explaining tests and treatments in alignment with the CCG average of 86% and the national average of 86%.
- 84% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82%, and the national average of 82%.

Patient and carer support to cope emotionally with care and treatment

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, and those at risk of developing a long-term condition.

The practice had coded 485 (2.8%) of their registered patients as carers. The clinical governance team consisting of two GPs and the practice manager acted in the role of 'Carers' Champion', and links had been established with the local carers association. New carers were recorded upon registration and were provided with a carer's information pack. The practice encouraged carers to receive vaccination against the flu virus, and offered support to carers as and when this was required. There was a display area within the reception for carers, and this provided signposting details to a range of local support organisations and group, as well as general information.

A monthly carer's clinic was provided on site by the carer's association. Whilst this clinic was primarily for carers at the practice, other carers registered with local practices could also be seen and benefit from receiving a full carers assessment. This clinic had been initially set up as a joint venture by the six local GP practices and subsequently

Are services caring?

received funding from the CCG to ensure its ongoing delivery. The CCG was rolling out this model across its other practices, in recognition of the benefits this created for both patients and their carers.

The practice worked with the wider multi-disciplinary team to deliver high quality end of life care for patients. The practice worked within the Gold Standards Framework (GSF) which is an approach to optimise care for all patients approaching the end of life. Advanced care planning was undertaken to ensure that patient's preferred wishes were taken into account, and appropriate patients were reviewed at the practice's quarterly palliative care multi-disciplinary team meeting.

Practice data for the preceding 12 month period demonstrated that 59 patients who had died had a preferred place of death recorded in their notes. Of these 59 patients, 41 had died in their preferred place of death (69.5%).

Following a patient death, a GP would usually call relatives or carers to offer condolences and assess if any additional support might be required. On occasions, the GP visited bereaved relatives depending on the particular circumstances and the level of involvement with each patient prior to their death. Information was available to signpost relatives or carers to appropriate services such as counselling where indicated.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG), to secure improvements to services where these were identified. For example, the practice had provided a vasectomy service for over 15 years for their patients. This had recently been extended within their CCG's area to enable patients from other practices to access this service, with the intention of improving patient choice and access to local treatment. The GP had performed 88 vasectomies in the past 12 months and received high levels of positive patient feedback. For example, 95% of patients said they felt either 'completely at ease' or very comfortable' during the procedure. This service was provided on a Thursday afternoon in order to minimise time off work for those receiving the service. The service achieved good clinical outcomes for patients with a 99.5% success rate over the last 18 months.
- A monthly carer's clinic was provided on site by the carer's association. Whilst this clinic was primarily for carers at the practice, other carers registered with local practices could also be seen at Jessop Medical Practice.
- The practice provided a range of services that ensured these were easily accessible for their patients. This included ambulatory and home blood pressure monitoring; spirometry (a test to assess lung function) and an in-check device to help patients use their inhalers correctly; ECGs to test the heart's rhythm; monitoring of patients prescribed medicines to thin their blood; travel vaccinations; Doppler testing; and some minor surgery including joint injections.
- The practice provided in-hours medical cover to the local community hospital in Ripley. This was operated by three GPs working on a rolling three-week rota to ensure continuity. Many of the patients were registered with the practice which enabled ongoing continuity of care when the patient was discharged home. We spoke with a matron at the hospital who described an excellent working relationship and said that GPs provided two ward rounds each week, as well as ad-hoc visits when this was required. GPs also provided telephone advice and had given staff their mobile numbers so that they could be contacted directly.
- The practice covered GP services to patients across 16 local care homes, each of which had at least one named GP allocated to their home. We spoke with managers at two homes who told us they were highly satisfied with the service provided. They told us that they had been consulted about regular ward rounds but it had been agreed that it would be more appropriate to have a service that responded to patients' needs as they arose. Managers said that GPs actively reviewed patients' medicines and had put care plans in place, and that they were responsive to the needs of residents receiving end-of-life care.
- The practice offered access to a full range of contraception services including long-acting reversible contraceptives such as injections, intrauterine devices (coils) and subdermal contraceptive implants.
- The site was easily accessible for patients with reduced mobility, with good access from the car park and automated entrance doors. All of the practice's consulting rooms were accessible on the ground floor with wide doorways, and the reception desk had a lowered section to speak easily with patients to accommodate wheelchair users. A hearing loop system was available within reception for patients with hearing difficulties, and information was available in different formats such as braille or large print for patients with a visual impairment as part of the NHS accessible information standard. Access to translation services and other communication support was provided.
- The waiting area contained a wide range of information on local services and support groups. This included information for carers, and local services available for patients with mental health issues. Health promotion material was displayed within the waiting area. A television screen displayed practice and general health information in the waiting area.
- Same day appointments were available for children and those patients with medical problems that required them to be seen urgently. Home visits were available for older patients and others with appropriate clinical needs which resulted in difficulty attending the practice.
- The reception area was spacious and maintained in good order. Patient confidentiality was managed appropriately by reception staff, and a radio was played to help patient conversations from not being overheard

by those in the waiting area. If patients became distressed, or wished to discuss a sensitive issue, they could move into a private room located close to the main reception desk.

- Patients could order repeat prescriptions on line. The practice participated in the electronic prescription service with 34% of their patients having a nominated pharmacy. This enabled patients to collect their medicines from their preferred pharmacy without having to collect the prescription from the practice. Each site had a 100-hour independent pharmacy located next to the practice meaning prescriptions could be collected out-of-hours.
- The practice had devised a scheme working with the local Borough Council Housing Officer to identify people at risk of fuel poverty. The practice had contacted their patients with severe breathing disorders to offer heating and housing advice, and this work had been presented nationally as best practice by the council.
- The practice hosted a weekly Citizen's Advice Bureau (CAB) session at both sites. During 2015-6, the CAB advisors had 201 client contacts at the surgery, and assisted 41% of them to access appropriate benefits and grants.
- The practice offered access to audiology services at both surgeries to assist patients in receiving support locally.
- A new model for emotional and mental health support for children was developed in local practices and schools. Funding for this project (Safespeak) had been secured from local Public Health and the CCG. Individual consultations could be arranged at the practice for children to access Safespeak.
- The practice had been inspected by the Care Quality Commission in January 2014 using the previous inspection methodology, and the practice was found to be compliant in all areas that were assessed. This report was displayed within the patient waiting area, enabling patients to access the findings of the report easily.
- The practice produced a patient newsletter. The most recent for autumn and winter 2016 included advice on winter weather and illnesses; information about the PPG; the annual flu vaccination campaign; and an update on the booking system for appointments.

Access to the service

The practice opened daily from 7.30am until 6.30pm. The main site and branch alternated late clinics on a Monday evening when the practice stayed open until 8pm.

GP consultations times commenced in the morning with extended hours opening from 7.30am. The last GP consultation was available at 5.50pm, apart from on a Monday evening when the last GP appointment being provided at 7.50pm. The practice offered some appointments throughout the lunchtime period and throughout most of their opening hours.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was mostly in line with local and national averages. The exception to this was patient access to their preferred GP, and the practice told us that in response they had added more routine phone calls for all doctors each day to help with continuity. The practice felt this had been partly a consequence following the retirement of GP partners in recent years, and hoped that patients were now happier in seeing other GPs.

- 79% of patients found it easy to get through to this surgery by phone compared to a CCG average of 72% and a national average of 73%.
- 87% of patients were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 85% and a national average of 85%.
- 75% of patients described their experience of making an appointment as good compared to a CCG average of 72% and a national average of 73%.
- 77% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 76%.
- 74% of patients usually waited 15 minutes or less after their appointment time to be seen compared to a CCG average of 69% and a national average of 65%.
- 29% of patients usually got to see or speak to their preferred GP, which was significantly below both the CCG average of 55% and the national average of 59%.

The partners were aware that there had been some negative feedback received in respect of access to appointments. This was an issue which the practice kept under constant review, and we observed that different systems had been trialled in an attempt to improve access. The current approach included increasing online bookings (including early and late appointments), the release of more appointments throughout the week, and increasing

the number of appointments with the nurse practitioner. The practice had also liaised with other GP practices to research other potential systems which could be applied to enhance patient experience in booking appointments.

The practice offered a variety of options to see or speak with a GP. This included pre-bookable appointments, same-day and urgent on-the-day appointments, and telephone consultations. On the day appointments were also available with the nurse practitioner who was trained to deal primarily with acute and minor illnesses, such as urinary and chest infections.

Patients could book between four to six weeks in advance to see a GP or a nurse. On the day of our inspection, we saw that the next available routine GP appointment was available in twelve working days' time. However, there was flexibility in the appointment system to provide alternative options. For example, a number of appointments could be booked one, two, three or seven days in advance and some were released each morning, so that patients could ring back to secure an earlier appointment if needed.

When GP appointments reached capacity, patients who requested an on-the-day consultation were allocated a telephone advice slot with the duty doctor. Patients who still required to be seen that day after the call were then given an appointment to see a GP or the nurse practitioner. Two duty doctors (one at each of the two sites) were available all day on Mondays and Fridays and during the mornings from Tuesday to Thursday. This helped to address the busiest periods.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- A named GP was the designated lead person that co-ordinated the complaints process.
- We saw that information was available to help patients understand the complaints system.

The practice had received 38 complaints in the last 18 months and we reviewed some of these and found they were satisfactorily handled and dealt with in a timely way with openness and transparency. If a patient asked for a complaints form at reception, staff would complete an incident form to ensure the issue was reviewed internally and any necessary learning could be considered.

Complaints were discussed at partners meetings and staff meetings. The practice offered to meet with complainants to discuss their concerns whenever this was deemed appropriate. The practice undertook an annual review of complaints to identify any trends and consider the learning points and changes to practice. Lessons were learnt and shared with the team following a complaint, and action was taken to as a result to improve the quality of care. For example, it was highlighted that clinicians should have heightened awareness of parents' concerns when they have had frequent contact with the practice for ongoing symptoms with a child. The learning identified was that in future this should flag the need for further investigation, and potentially a second opinion within the team.

Are services well-led?

Outstanding ☆

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- The partnership had an ethos that patients were at the heart of their work, and that the service strove towards excellence. The practice constantly adapted to ensure it was responsive to patients' needs and their feedback.
- The management team were able to articulate their priorities which formed their basis of their future strategic direction. This was supported by a comprehensive three-year business plan supported with agreed actions, goals and objectives to reflect the aspirations of the partnership. All partners took part in an annual strategic planning day held at the weekend, and this informed their business planning process. Practice staff and patient groups were welcomed to put forward proposals for consideration and were consulted on various aspects of decision-making as part of an inclusive approach.
- A full partners' meeting was held every month during an evening to avoid disruption to clinical sessions. Shorter half-hour meetings were held each week to discuss and manage the day-to-day running of the business. We observed that both meetings were documented.
- The partners actively looked to improve outcomes for their own patients as well as having a wider community focus and actively seeking to deliver care to all patients nearer to home.

Governance arrangements

The practice had a strong, embedded and effective governance framework that ensured the delivery of good quality care.

- A Clinical Governance team consisting of two GPs, a Nurse Practitioner and the Assistant Practice Manager met regularly. Every opportunity to learn from events was identified, recorded and used to improve practice.
- There was a clear team structure in place, and staff were aware of their own roles and responsibilities. GPs and nurses had defined lead clinical areas of responsibility. The GPs and nurses had defined lead clinical areas of responsibility including mental health, sexual health and contraception, and end of life care.
- The practice had purchased an electronic document management system to enable easier access to the practice intranet. This enabled all practice documentation to be kept within one organised and structured system with relevant access for each staff group.
- Systems were in place for identifying, recording and managing risk, and implementing mitigating actions.
- A range of practice specific policies had been implemented, and were available to all staff.
- An understanding of the performance of the practice was maintained which included the analysis and benchmarking of QOF performance, and referral and prescribing data. Actions were undertaken when any variances were identified and these were effective in securing improvements.

Leadership and culture

- The partnership included 13 GPs and the practice manager. There was a history of non-medical partners as a nurse practitioner had also been a member of the partnership until their retirement in 2015. The provider felt this gave a well-rounded approach to decision-making processes within the partnership. They adopted a non-hierarchical approach with all partners taking on a different area of responsibility within the practice.
- Management meetings were held each week. This consisted of two senior GP partners, the nurse manager and the practice manager partner.
- Clinical staff worked across both sites, whilst the reception and administrative teams generally remained in one base. All staff came together each month for a full staff meeting. Non-clinical staff told us that this arrangement worked well and that they were not isolated, and felt that they were a unified team. High-speed computer links between the two sites, including an instant messaging system, ensured effective communication channels.
- The previous two years had seen a period of change and transition within the partnership and management team, following a merger with another local practice in 2014. The two practices varied considerably in terms of size and working practice, including the operation of their appointment systems and patient records. Since the merger, the partners, staffand the practice PPG had worked hardto amalgamate services and integrate the patients and staff of the two practices. Despite these changes, the practice had managed to ensure continuity of the service without impacting upon patient care and

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experience. The new managerial arrangements had become quickly embedded and we observed that the practice was functioning well and effectively to ensure high quality care. Staff told us that they felt they were part of one integrated team following the merger.

- The practice proactively engaged with their CCG and worked with them to enhance patient care and experience. A GP partner had a variety of roles with the CCG including being a commissioning lead, a member of clinical improvement groups, the GP prescribing lead, and was an audit committee member. Another GP partner was a member of the Planned Care board. There was regular attendance from the surgery at CCG events and good engagement at practice visits. The surgery also participated in locality meetings, practice manager forums and CCG led protected learning time events. Involvement within these different workstreams assisted joint learning and sharing best practice with other GP surgeries.
- The practice had traditionally worked with their neighbouring five local GP practices and in 2015 the Amber Valley Collective was created with input from the Local Medical Committee to further promote collaborative working. This led to the development of a memorandum of understanding and risk sharing agreement between all six practices. Achievements included the employment of notes summarisers who worked across four of the six practices. Other areas of collaboration had been explored and the Collective were working to produce a staff contract and handbook with a HR consultant suitable for groups of practices to use.
- With the move to place-based working, the practice was considering their local population's health needs and future service delivery with other practices within their area. The CCG supported sub-locality meetings were in development to become a 'place' under the implementation of the five year NHS plan, with the six practices have a combined population of approximately 55,000 patients and a history of collaboratively working. This initiative had already led to the development of a service for emotional and mental health support for children and the implementation of carer's clinics which could be accessed by the six local practices.
- The partners took a proactive approach with succession planning arrangements. For example, skill mix arrangements were being implemented with the recent appointment of a salaried GP, and a new advanced nurse practitioner was due to start at the practice in November 2016. The new nurse practitioner had already met with the partners to look at how to develop this role jointly, and where possible to push boundaries and create a role that best met the emerging demands on patient care.
- The practice was an accredited training practice and three of the GPs acted as trainers to support registrar placements. Medical students from Nottingham and Derby were also hosted within the practice. This added to the learning environment which was pivotal to the practice ethos of continuous education and to strive towards excellence. We spoke to the GP registrar working at the practice at the time of our inspection and were told that they felt very well supported and had ongoing access to advice, training and debriefing sessions.
- As part of their input to the local community hospital, partners attended a six-monthly review meetings with their commissioner. At their last meeting the commissioner expressed satisfaction with the service provided and indicated a desire to model their contracts with other GP providers within hospitals in the same way.
- Staff told us there was an open culture within the practice and said the GPs and practice manager were visible within the practice and were approachable, and always took the time to listen to all members of staff. Staff said they felt respected, valued and supported by the GPs and the practice manager.
- Staff told us the practice held monthly staff meetings during which they had the opportunity to raise any issues. This meeting incorporated all staff working across both sites. Staff told us that they felt confident and supported in doing so. The team used the meeting as an opportunity to review incidents and complaints. Minutes from this meeting were documented.
- The partners told us that they aimed to instil a stress-free and lively environment which encouraged employees to remain focused and project a positive attitude to the patients. Staff we spoke with told us that the practice was a good place to work, and the team supported each other to complete tasks. Team building events had been organised by the practice, and the practice team occasionally met outside of work for social events.

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Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through patient surveys; the suggestion box; via complaints received; responses from the NHS Choices website; and responses received as part of the Families and Friends Test (FFT).
- The practice undertook patient surveys to complement the national GP patient survey. A total of 541 (3.3%) patients were surveyed in January 2016 via a validated patient feedback tool using an external company to analyse the results. An outcome was that the practice identified that access to GP appointments was an issue and a text reminder service was introduced to reduce patient numbers who did not attend. An annual patient satisfaction survey was undertaken with patients who had received a vasectomy at the practice, and results were overwhelmingly positive.
- The practice had a patient participation group (PPG) with a core membership of between six to eight members regularly attended bi-monthly meetings. There is also an extended virtual network of approximately 30 members, who communicate with the group via e-mail. A GP and the practice manager would always try to attend the PPG meetings, or would identify a deputy to ensure that members of the practice team were available at every meeting. We spoke with two members of the current PPG, and the recently retired former chair, who all described a positive relationship with the practice, and expressed that they were extremely satisfied in how the practice was run. The PPG's achievements included changes to the appointment system to improve access. The practice had also displayed names and photographs of staff in response to PPG feedback, so that patients were more aware of the practice team. The PPG undertook an annual patient survey during their assistance with the flu vaccination clinic, and we saw that an action plan had been developed in response to the findings in January 2016. This had been updated with progress in September 2016. The practice had a dedicated PPG noticeboard within the reception area. Minutes were produced from the PPG meeting although these were not displayed minutes on the notice board or the practice website. In alignment with the practice's development of place-based working, plans were being considered to link up with PPGs across the locality to share ideas and work more collaboratively.
- The practice had an undertaken a staff survey in 2015. This produced positive outcomes including 95.5% staff stating that they 'strongly agreed' that they had received support from senior staff colleagues in the previous six months. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with their management team, and informed us that they felt involved and would contribute suggestions to improve how the practice was run.

Continuous improvement

- The practice had a history of working jointly with their neighbouring practices, and a collective had been created to develop collaborative ways of working and the sharing of resources. Achievements included the employment of notes summarisers who worked across this group of six practices and the development of a service for emotional and mental health support for children. The practice was also proactive in the development of place-based working to work collaboratively across a defined geographic area to meet the needs of the population, and provide more joined-up care. This placed the practice at the forefront of local developments in health care.
- The practice was registered as a pilot practice for MyGP247. This is a locally developed patient website which uses sophisticated algorithms to signpost patients to appropriate care, based on symptoms. This includes online advice, email communication with GPs, or appointments where appropriate. The intention is that when the project goes live it will offer further convenience and accessibility for patients.
- The practice had provided patient access to their full clinical record since April 2016. This had been agreed as it was felt that coded information was limited in scope for its usefulness. For patients, this provided an opportunity to look back at their records and to view hospital letters. This gave them a greater understanding of their condition and thereby the ability to make more informed lifestyle choices. Fifty initial requests had been received from patients to access this service, and subsequently a few requests were received each week. The GPs continued to promote the service to patients,

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particularly to those whom may benefit from access. NHS England were using this as an example of successful implementation of patient online access to records and had sent this as a case study to send to other practices to encourage uptake.

- The practice had been involved in setting up new community psychiatric nurse clinics within local practices which was due to start in the near future.
- The practice was part of a provider company formed from GP practices within southern Derbyshire and south and east Staffordshire, enhancing access to care across a wider geographical area.